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TRANSITIONAL CARE: THE MULTIDISCIPLINARY TEAM AS A FACILITATING AGENT IN THE HOSPITAL DISCHARGE PROCESS

O CUIDADO TRANSICIONAL: A EQUIPE MULTIPROFISSIONAL COMO AGENTE FACILITADOR NO PROCESSO DE DESOSPITALIZAÇÃO

CUIDADOS TRANSITORIOS: EL EQUIPO MULTIDISCIPLINARIO COMO AGENTE FACILITADOR EN EL PROCESO DE DESHOSPITALIZACIÓN

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ABSTRACT: The patient's transition process from the hospital environment to home is known as Hospital Discharge. This arises due to the need for humanization, biosafety, and reduction in hospitalization time, bringing benefits to the health system and the patient himself. **Objective:** This work aims to report the experience of a multidisciplinary team, developed through the Hospital Discharge Support Commission (CADES) in a public hospital in Fortaleza-Ce. **Methodology:** Reflections were promoted based on the monitoring of a multidisciplinary team focused on Hospital Discharge, in addition to observations of the functioning of the service and notes in a field diary. **Conclusion:** It is concluded that the actions carried out by the CADES team in the hospital discharge process are fundamental, as they guarantee individualized transitional care that meets the demands of the SUS and current society.

KEYWORDS: Hospital Discharge. Transitional Care. Multidisciplinary team. Health education.

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RESUMO: *O processo de transição do paciente do ambiente hospitalar para o domicílio é conhecido como desospitalização. Este surge devido à necessidade de humanização, de biossegurança e redução do tempo de internação, trazendo benefícios tanto para o sistema de saúde como também ao próprio paciente.* ***Objetivo:*** *é relatar a experiência do trabalho de uma equipe multiprofissional, desenvolvido através da Comissão de Apoio à Desospitalização (CADES) em um hospital público de Fortaleza (CE).* ***Metodologia:*** *Foram promovidas reflexões a partir do acompanhamento de uma equipe multiprofissional voltada para a desospitalização, além de observações do funcionamento do serviço e anotações em diário de campo.* ***Conclusão:*** *é fundamental as ações realizadas pela equipe do CADES, no processo de desospitalização, pois garantem um cuidado transicional individualizado, atendendo às demandas do SUS e da sociedade atual.*

PALAVRAS-CHAVE: *Desospitalização. Cuidado Transicional. Equipe Multiprofissional. Educação em Saúde.*

RESUMEN: *El proceso de transición del paciente del entorno hospitalario al domicilio se conoce como deshospitalización. Esto surge por la necesidad de humanización, bioseguridad y reducción del tiempo de hospitalización, trayendo beneficios tanto para el sistema de salud como para el propio paciente.* ***Objetivo:*** *El objetivo de este estudio es relatar la experiencia del trabajo de un equipo multiprofesional, desarrollado a través de la Comisión de Apoyo a la Deshospitalización (CADES) en un hospital público de Fortaleza-CE.* ***Metodología:*** *Se promovieron reflexiones a partir del seguimiento de un equipo multiprofesional enfocado en la deshospitalización, además de observaciones sobre el funcionamiento del servicio y anotaciones en un diario de campo.* ***Conclusión:*** *Se concluye que las acciones llevadas a cabo por el equipo del CADES en el proceso de deshospitalización son fundamentales, ya que garantiza una atención transitoria individualizada, atendiendo a las demandas del SUS y de la sociedad actual.*

PALABRAS CLAVE: *Deshospitalización. Cuidado Transicional. Equipo Multiprofesional. Educación en Salud.*

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INTRODUCTION

The need for hospitalization resulting from the increasing incidence of chronic diseases contrasts with the historical evolution of care for these conditions. The management and control of these diseases remain predominant challenges in healthcare systems globally and in Brazil. This scenario is reflected in the demands associated with home return and transitions between levels of care.

Dehospitalization arises from the need for humanization, biosafety, and the reduction of hospitalization time, offering advantages both for the healthcare system and the patient. This process, known as dehospitalization, aims to provide faster, more precise, efficient, and personalized recovery.

Therefore, it is a procedure closely linked to humanization, promoting a quick recovery perspective and optimizing the use of hospital beds, allowing patients to receive care without the need for prolonged hospitalization. Dehospitalization requires a multidisciplinary team capable of meeting the needs of users of the Unified Health System (SUS). This team must plan, organize, and educate patients for home return, minimizing the risks of family-related complications.

The humanized approach of these professionals plays a crucial role in the patient's transition to home care, providing guidance on supplies, user rights, and health education for caregivers. The responsibility of the multidisciplinary team in developing a comprehensive discharge plan for the patient during and after hospitalization is emphasized, with a patient-centered focus and family involvement to ensure continuity and quality of home care.

In SUS, care transition is crucial, involving planned care during changes in the patient's health condition or transition between levels of care, integrating different points of the Health Care Network. Strategies such as discharge planning, advance care planning, complete communication of information, patient and caregiver education, self-management promotion, medication safety, and post-discharge follow-up are essential to ensure effective transitions.

This study highlights the importance of investigating dehospitalization, a topic still underexplored in academic literature, and underscores the global trend of transitional care in response to the challenges of hospital discharge and the need to ensure continuity of care across different levels of healthcare. The aim of this work is to report the experience of a multidisciplinary team developed through CADES in a public hospital in Fortaleza (CE).

METODOLOGY

This is a descriptive study with a qualitative methodological approach that reports the experiences of a multidisciplinary team at a public hospital in the state of Ceará, during the

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period from December 2023 to January 2024. The study involved professionals from various fields, such as physiotherapists, nurses, nursing technicians, doctors, and social workers. The record of experiences was made through a field diary containing observations on the functioning of the service.

According to Mussi, Flores, and Almeida (2021), experience reports are a form of knowledge production about academic and/or professional experiences, characterized by the description of a specific topic, contributing to the production of various types of knowledge and recognizing the importance of discussing a particular theme. In the academic context, descriptive research presents the characteristics of a population, sample, or group, summarizing the necessary aspects for better understanding of the study participants (Scorsolini-Comin, 2021).

The survey of scientific productions was conducted in various electronic databases, such as SciELO, LILACS, Google Scholar, and the CAPES Periodicals Portal, in addition to books. Full-text articles in Portuguese were selected, excluding incomplete articles, articles in English, duplicates, reviews, conference proceedings, and editorials. Twelve articles were chosen for analysis.

The activities described in this study correspond to those carried out by the multidisciplinary team of the Dr. José Frota Institute Hospital (IJF), a tertiary-level unit with regional reference for the treatment of high-complexity trauma, severe vascular injuries, burns, and acute intoxications.

The activities performed by this team provide a rich experience in multidisciplinary work, highlighting the importance of collaboration and synergy for the success of the dehospitalization process.

Considering the nature of the study, it was concluded that submission to the Research Ethics Committee was not necessary. However, the ethical principles of resolutions No. 466/2012 and No. 510/2016 were fully incorporated into the process, and absolute confidentiality was maintained regarding the identification of patients, followed by the multidisciplinary team (Brasil, 2012; 2016).

RESULTS AND DISCUSSION

The CADES team is responsible for the deshospitalization of clinically stable patients who will require prolonged care at home, ensuring the continuity of care in a safe and humanized manner.

The study by Knihs et al. (2020) highlights the necessary adaptations for the new home reality, where adult patients face uncertainties, fears, and doubts about performing daily care and managing signs and symptoms, as well as the emotional impact of adapting

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to a new routine.

Currently, CADES plays an essential role in healthcare service by managing the discharge of clinically stable patients, optimizing hospital beds, reducing costs, minimizing adverse in-hospital events, and ensuring transitional care. The committee's proposal aligns with the World Health Organization's (WHO) alert regarding the importance of transitional care since 2016, promoting benefits such as continuity of care, improved relationships between patients, families, and caregivers, increased bed availability, and reduced hospital costs.

However, the discharge moment can be vulnerable, particularly for patients with multiple comorbidities, depending on factors such as dependency level, support network, and access to specialized healthcare services. To minimize failures and optimize safe discharge, the CADES multiprofessional team conducts routine visits to identify patients who will require prolonged care at home, providing guidance to caregivers and developing individualized discharge plans.

The study by De Souza et al. (2023) reports a similar experience in a high-complexity private hospital, emphasizing the active search for eligible patients for deshospitalization and the importance of interprofessional collaboration in discharge planning. The review by Delatorre et al. (2013) underscores the importance of the multi-professional team's collaboration in discharge planning, aiming to understand and maintain continuity of home care to ensure the quality of life and the patient's return to social and family life.

Training the patient's caregiver is essential to reduce errors in-home care and prevent readmissions due to infections acquired in the home environment, as emphasized by Silva et al. (2022). Educational practices during hospitalization are crucial for improving communication between the healthcare team, family, and caregiver, fostering autonomy in care.

FINAL CONSIDERATIONS

From the experiences reported, there is a clear understanding of the importance and magnitude of the de-hospitalization process carried out by CADES within the hospital environment. Furthermore, it is possible to identify how the work of the multiprofessional team can positively impact this transitional care process, bringing benefits to patients, society, and the hospital network itself.

Thus, the emphasis on discharge planning for de-hospitalization is key to the success of patient discharge. Through this process, the patient's real needs are identified, and the necessary guidance for effective care is provided, positively reverberating in the communication between the team, patient, and/or family, enabling a safe and humanized discharge.

Therefore, it is evident that de-hospitalization goes beyond training the caregiver in

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the process of caring, medicating, aspirating, feeding, or changing the patient. It is a process that requires the involvement of the family/caregiver in co-participation in the care process, as they are essential figures in supporting the patient's daily care.

Consequently, for effective de-hospitalization, a committed and cohesive multidisciplinary team is required to organize and plan the care transition and improve care quality after hospital discharge. This team should focus on preparing the support network, making referrals to Primary Care, and ensuring that all necessary materials, medications, and other supplies are available for home use, guaranteeing patient care continuity.

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Ethical approval: This work complied with ethics during its development. It was not submitted to an ethics committee because it is an experience report describing only the professional experiences of the researchers in this study.

Availability of data and materials: The data and materials used in this study are available in the Scientific Electronic Library Online (SciELO); in the Latin American and Caribbean Literature in Health Sciences (LILACS), in the Google Scholar search tool, and in the CAPES Journals Portal, as well as in books.

Author contributions: As a physiotherapist on the committee described in the article, Dinara Rute was responsible for writing the introduction, objectives, results and discussion. In these points, the author tried to give a better account of her professional experience and describe a little about dehospitalization based on the scientific literature. The author, Tannara Patrícia, was responsible for developing the methodology of this study, the final considerations and the search for data and materials in the databases used to write the article. The author Stela was responsible for guiding and revising the article in accordance with the journal's standards.

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